

(i) Keep copies of all these requests and the responses to them;

(ii) Make them available to the Secretary or the Medicaid agency upon request; and

(iii) Advise the Medicaid agency when there is no response to a request.

(b) *Time and manner of disclosure.* (1) Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified in paragraph (a) of this section to the State survey agency at the time it is surveyed. The survey agency must promptly furnish the information to the Secretary and the Medicaid agency.

(2) Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified in paragraph (a) of this section to the Secretary within the prior 12-month period, must submit the information to the Medicaid agency before entering into a contract or agreement to participate in the program. The Medicaid agency must promptly furnish the information to the Secretary.

(3) Updated information must be furnished to the Secretary or the State survey or Medicaid agency at intervals between recertification or contract renewals, within 35 days of a written request.

(c) *Provider agreements and fiscal agent contracts.* A Medicaid agency shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section.

(d) *Denial of Federal financial participation (FFP).* FFP is not available in payments made to a provider or fiscal agent that fails to disclose ownership or control information as required by this section.

**§ 455.105 Disclosure by providers: Information related to business transactions.**

(a) *Provider agreements.* A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information

related to business transactions in accordance with paragraph (b) of this section.

(b) *Information that must be submitted.* A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—

(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

(c) *Denial of Federal financial participation (FFP).* (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).

(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

**§ 455.106 Disclosure by providers: Information on persons convicted of crimes.**

(a) *Information that must be disclosed.* Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

(b) *Notification to Inspector General.* (1) The Medicaid agency must notify the Inspector General of the Department of

any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) *Denial or termination of provider participation.* (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

## PART 456—UTILIZATION CONTROL

### Subpart A—General Provisions

Sec.

- 456.1 Basis and purpose of part.
- 456.2 State plan requirements.
- 456.3 Statewide surveillance and utilization control program.
- 456.4 Responsibility for monitoring the utilization control program.
- 456.5 Evaluation criteria.
- 456.6 Review by State medical agency of appropriateness and quality of services.

### Subpart B—Utilization Control: All Medicaid Services

- 456.21 Scope.
- 456.22 Sample basis evaluation of services.
- 456.23 Post-payment review process.

### Subpart C—Utilization Control: Hospitals

- 456.50 Scope.
- 456.51 Definitions.

#### CERTIFICATION OF NEED FOR CARE

- 456.60 Certification and recertification of need for inpatient care.

#### PLAN OF CARE

- 456.80 Individual written plan of care.

#### UTILIZATION REVIEW (UR) PLAN: GENERAL REQUIREMENT

- 456.100 Scope.
- 456.101 UR plan required for inpatient hospital services.

#### UR PLAN: ADMINISTRATIVE REQUIREMENTS

- 456.105 UR committee required.
- 456.106 Organization and composition of UR committee; disqualification from UR committee membership.

#### UR PLAN: INFORMATIONAL REQUIREMENTS

- 456.111 Recipient information required for UR.
- 456.112 Records and reports.
- 456.113 Confidentiality.

#### UR PLAN: REVIEW OF NEED FOR ADMISSION

- 456.121 Admission review required.
- 456.122 Evaluation criteria for admission review.
- 456.123 Admission review process.
- 456.124 Notification of adverse decision.
- 456.125 Time limits for admission review.
- 456.126 Time limits for final decision and notification of adverse decision.
- 456.127 Pre-admission review.
- 456.128 Initial continued stay review date.
- 456.129 Description of methods and criteria: Initial continued stay review date; close professional scrutiny; length of stay modification.

#### UR PLAN: REVIEW OF NEED FOR CONTINUED STAY

- 456.131 Continued stay review required.
- 456.132 Evaluation criteria for continued stay.
- 456.133 Subsequent continued stay review dates.
- 456.134 Description of methods and criteria: Subsequent continued stay review dates; length of stay modification.
- 456.135 Continued stay review process.
- 456.136 Notification of adverse decision.
- 456.137 Time limits for final decision and notification of adverse decision.

#### UR PLAN: MEDICAL CARE EVALUATION STUDIES

- 456.141 Purpose and general description.
- 456.142 UR plan requirements for medical care evaluation studies.
- 456.143 Content of medical care evaluation studies.
- 456.144 Data sources for studies.
- 456.145 Number of studies required to be performed.

### Subpart D—Utilization Control: Mental Hospitals

- 456.150 Scope.
- 456.151 Definitions.